

Professional Law Enforcement Association

Vision Care Insurance brought to you by PLEA



Vision Benefit Overview	Examination	Spectacle Lenses	Frames	Contact Lenses
Benefit Frequency	▶ Once every twelve (12) months (Valid on plans 1, 2 & 3)	▶ Once every twelve (12) months (Valid on plans 1, 2 & 3)	▶ Once every twenty-four (24) months (Valid on plans 1, 2 & 3)	Once every twelve (12) months (Valid on plans 1, 2 & 3)
Amount of coverage at Participating providers	▶ 100% of cost less a \$10.00 co-payment (Valid on plans 1, 2 & 3)	▶ 100% of cost less a \$10.00 co-payment (Valid on plans 1 & 2) ▶ 100% of cost less a \$25.00 co-payment (Valid on plan 3)	▶ 100% up-to \$100.00 (Valid on plan 1) ▶ 100% up-to \$120.00 (Valid on plan 2 & 3)	▶ 100% up-to \$100.00 (Valid on plan 1) ▶ 100% up-to \$115.00 (Valid on plan 2 & 3)
Amount of coverage when services are acquired Out-of-Network	▶ 100% of cost less a \$30.00 co-payment (Valid on plans 1, 2 & 3)	▶ \$25.00 Single-Vision ▶ \$35.00 Bifocal ▶ \$45.00 Trifocal ▶ \$45.00 Lenticular (Valid on plans 1, 2 & 3)	▶ \$50.00 (Valid on plan 1) ▶ \$70.00 (Valid on plan 2 & 3)	▶ 100% up-to \$80.00 Elective & \$200.00 on Medically Necessary (Valid on plan 1) ▶ 100% up-to \$90.00 Elective & \$220.00 on Medically Necessary (Valid on plan 2 & 3)
Medically Necessary Contact Lenses	In instances where contact lenses are determined to be medically necessary, coverage will be at 100% of the provider's reasonable and customary fee up to the dollar amount indicated in the above table. Prior authorization is required – Valid on plans 1,2 & 3			

- ▶ Please read the Benefits Overview carefully in order to distinguish the difference between plans 1, 2 & 3.

Product Highlights

- ▶ Vision Care is always rated at or near the top of the list of benefits most desired by members
- ▶ Vision Care programs may help eliminate loss in productivity and absenteeism due to headaches, eyestrain and fatigue
- ▶ Program offers a large national network of tens of thousands of participating Ophthalmologists, Optometrists and Opticians
- ▶ Proper vision care can help in the detection of certain medical conditions such as diabetes and multiple sclerosis
- ▶ Programs are simple to use and do not require use of claim forms

Voluntary Rates

Plan #	Member Only	Member Plus One	Member Plus Two or More
1	\$6.41	\$11.54	\$16.66
2	\$7.02	\$12.63	\$18.25
3	\$6.02	\$10.83	\$15.64

To acquire a hardcopy of coverage details, please contact:

Ms. Leslie McMahon, Executive Director
Professional Law Enforcement Association

P.O. Box 1197 • Troy, MI 48099-1197

Toll-Free Phone: 800.367.4321 ext. 1010 or;

Fax: 248.641.8857



The Domestic Accident & Health Division of American International Companies has made arrangements with National Vision Administrators, L.L.C., to deliver a high-quality, cost-effective vision plan to PLEA members. Underwritten by National Union Fire Insurance Company of Pittsburgh, P.A., with its principal place of business in New York City, NY. This document serves only as a brief description of the coverage(s) available. The physical AIG Policy will contain reductions, limitations, exclusions and termination provisions.



**INDIVIDUAL APPLICATION
FOR VISION COVERAGE
(Please Print or Type)**

Employer (Group) Name P L E A - PROFESSIONAL LAW ENFORCEMENT ASSOCIATION		Group No./ Division / Class 50598	
Applicant's Last Name	First	Middle Initial	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number - Last 4 digits only		Date of Birth: (Month / Day / Year)	
Street Address		City	State Zip
Telephone #: () _____		Email: _____	
VISION COVERAGE TYPE REQUESTED: <input type="checkbox"/> Member <input type="checkbox"/> Member + One <input type="checkbox"/> Member + Two or More <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3			

EFFECTIVE DATE: First Of Following Month After Approval

NOTE: IF PAYING BY CHECK, PLEASE SEND ONE YEARS PREMIUM

COMPLETE: THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

LAST NAME	FIRST	INITIAL	STUDENT (Yes No)	M / F	DATE OF BIRTH Month / Day / Year
Spouse					

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE / SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR VISION COVERAGE.

SIGNATURE _____ DATE _____

Enclose your annual check or fill in your Visa / Mastercard information below.



This plan is administrated by Republic Underwriters, Inc.

Leslie A. McMahon, Executive Director
Professional Law Enforcement Assoc.
P.O. Box 1197
Troy, MI 48099-1197
1-800-367-4321, Ext. 1010
FAX: 1-248-641-8857
<http://www.plea.net>

Name: _____
Card Number: _____
Expiration Date: _____
Signature: _____

Please Rebill my card Annually.